Survivorship – Cutaneous Melanoma

ELIGIBILITY

Melanoma post-treatment and NED

CONCURRENT COMPONENTS OF VISIT

- **SURVEILLANCE**
- **MONITORING FOR LATE and/or CHRONIC EFFECTS**
- **RISK REDUCTION/ EARLY DETECTION**
- **PSYCHOSOCIAL FUNCTIONING**
- **CHRONIC HEALTH MAINTENANCE**

→ See Page 3

RECOMMENDED STAGE-GROUP STRATIFIED REFERRAL TO SURVIVORSHIP CLINIC

Stage 0, NED at 6 months[1] →
Stage 0: Year 1 and up
- Annual history and physical examination to include complete skin[2] and lymph node basin survey
- Reinforce skin inspection patient education

Stage IA, NED at 2 years[1] →
Stage IA: Years 3 and up
- Annual history and physical examination to include complete skin[2] and lymph node basin survey
- Reinforce skin inspection patient education

Stages IB – IIA, NED at ≥ 3 years[1] →
Stages IB - IIA: Years 4 and up
- Annual history and physical examination to include complete skin[2] and lymph node basin survey
- Reinforce skin inspection patient education
- Chest x-ray as clinically indicated
- Ultrasound of nodal basin as clinically indicated

Stages IIB – IIC, NED at ≥ 3 years[1] → See Page 2

Stages III – IV, NED ≥ 3 years and/or start of immunotherapy ≥ 3 years and off systemic therapy for 1 year[1] → See Page 2

DISPOSITION

Positive findings?

- Yes → Return to primary treating physician
  - **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[3]
- No → Continue survivorship monitoring

NED = no evidence of disease

[1] All patients with multiple melanomas should be transitioned based on number of disease free years with regards to the highest stage melanoma or number of disease free years for the last treated melanoma whichever is longer

[2] Patients should receive regular skin surveys by a provider experienced with skin cancer detection. Particularly high risk patients (*e.g.,* multiple primary tumors, clinically dysplastic nevi) may benefit from specialty dermatology care.

[3] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

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CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

RECOMMENDED STAGE-GROUP STRATIFIED REFERRAL TO SURVIVORSHIP CLINIC

Stages IIB – IIC, NED at ≥ 3 years[1]

Stages IIB - IIC: Years 4 and 5
- Annual history and physical examination to include complete skin[2] and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT every 6 months or chest x-ray as clinically indicated
- MRI brain with contrast as clinically indicated

Stages IIB - IIC: Years 6 and up
- Annual history and physical examination to include complete skin[2] and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT or chest x-ray as clinically indicated
- MRI brain with contrast as clinically indicated

Stages III – IV, NED ≥ 3 years and/or start of immunotherapy ≥ 3 years and off systemic therapy for 1 year[1]

Stages III - IV: Years 4 and 5
- Annual history and physical examination to include complete skin[2] and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT every 6 months or chest x-ray as clinically indicated
- MRI brain with contrast as clinically indicated

Stages III - IV: Years 6 and up
- Annual history and physical examination to include complete skin[2] and lymph node basin survey
- Reinforce skin inspection patient education
- CT chest, abdomen, and pelvis with contrast or PET-CT or chest x-ray annually as clinically indicated
- MRI brain with contrast as clinically indicated

DISPOSITION

Positive findings?

Yes → Return to primary treating physician
- **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[3]

No → Continue survivorship monitoring

[1] All patients with multiple melanomas should be transitioned based on number of disease free years with regards to the highest stage melanoma or number of disease free years for the last treated melanoma whichever is longer

[2] Patients should receive regular skin surveys by a provider experienced with skin cancer detection. Particularly high risk patients (*e.g.,* multiple primary tumors, clinically dysplastic nevi) may benefit from specialty dermatology care.

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CONCURRENT COMPONENTS OF VISIT

MONITORING FOR LATE and/or CHRONIC EFFECTS

Consider:
- Physical therapy (PT) for lymphedema assessment and management
- Range of motion
- Assess and manage autoimmune complications[1]
  - Co-manage chronic autoimmune adverse events with appropriate organ site specialist
  - Evaluate newly emergent inflammatory conditions as potential late autoimmune adverse events

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[2]
  - For patients with light and medium-toned skin, assess current and past ultraviolet radiation (UVR) exposures. Provide guidance regarding sun protective clothing, sunscreen use, seeking shade, and avoiding tanning bed exposure.
- Cancer screening[3]
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management, Hepatitis C Virus (HCV) Screening algorithms)
- Consider cardiovascular risk reduction (see Survivorship – Adult Cardiovascular Screening algorithm)
- Vaccinations[4] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Body image
- Financial stressors
- Social support

CHRONIC HEALTH MAINTENANCE

- Confirm primary care provider (PCP) or recommend establishing care with a local PCP
- PCP responsible for assessment and management of non-cancer chronic health conditions (hyperlipidemia, diabetes, hypertension, *etc.*) or refer as indicated

DISPOSITION

Refer or consult as indicated

[1] Though most immune-related adverse events (irAEs) occur while on immunotherapy, some irAEs can manifest late and/or treatment-emergent irAEs may become chronic. Endocrine organ irAEs (*i.e.* hypothyroidism, adrenal insufficiency, Type 1 Diabetes Mellitus) are permanent and must be treated with life-long hormonal replacement with appropriate monitoring. Other irAEs, most commonly rheumatological or neurological, may be chronic or relapsing/remitting and require chronic immunosuppression. These chronic irAEs should be co-managed with appropriate organ site specialist. Thyroid function should be monitored annually in patients with immunotherapy exposure and the possibility of late irAEs considered for new inflammatory issues.

[2] See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

[3] Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening

[4] Based on American Society of Clinical Oncology (ASCO) guidelines

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SUGGESTED READINGS

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MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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